Find your account balance at www.flexamerica.com

Question? E-mail support@flexamerica.com

FlexAmerica Claim Form

-DO NOT USE A FAX COVER PAGE-

DATE: _____

OF PAGES: _____

Claim Filing & Documentation Instructions

1) Provide ALL of the information requested on this claim form. Incomplete or unclear information will result in processing delays.
2) Attach an Explanation of Benefits (EOB) or itemized bill from the provider showing the provider name, expense description, date of service, amount paid and, if applicable, amount covered by insurance. Credit card receipts, canceled checks, and cash register receipts are not acceptable.
3) Attach itemized bills, with service date, from provider of qualifying expenses (e.g., co-pays, physician exams, glasses etc.).
4) Enter dependent reimbursement requests in the box at the bottom of the form.
5) Submit pharmacy receipts showing date of service, prescription (Rx) name and number and total amount. Credit card receipts, canceled checks, and cash register receipts are not acceptable.
6) You must submit claims before your grace period ends (usually 60 to 90 days after the plan year ends--check with your HR Department).

Checks are mailed each Thursday for claims received by Tuesday.

Employer Name

Check ONE **(REQUIRED)**: o NEW claim o Resubmitted claim

Employee Name	Daytime Phone Number	Social Security Number

Street Address: _____ City _____ State _____ ZIP Code _____

Check here if this a new address: o Email Address_____

q **CHECK HERE if you are submitting Debit Card verification receipts at FlexAmerica's request.**

Flexible Spending Account Reimbursement
(Enter the following information for EACH attached receipt)

Do not use this area to enter dependent day care claims.

Account Type (Healthcare, Parking, Transit, HRA, HSA, Premium Reimbursement, etc.)	Dates of Service (from / to)	Reimbursement Amount Requested	Provider Name	Type of Service or Prescription (Rx) Number	Family Member Name, if applicable
	ENTER TOTAL:				

Dependent Care Spending Account Reimbursement
(enter the following information for ALL attached receipts)

Use this space for dependent day care expenses only	Dependent Care Expense Total Amount	Provider's Signature (required if receipt is not provided)	Provider Tax ID or Social Security Number	
	Date(s) of Service	Provider's Address		Age of Dependent(s)

Employee Certification

I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents and are not payable by any other plan and will not be deducted on my federal, state or local income tax returns.

Employee Signature (**REQUIRED**) **DATE**

Comments on your claims:

Fax or mail claims to FlexAmerica, Inc., P.O. Box 341130 West Bethesda, MD 20827
Phone 301.530.9400/Fax 301.564.5191(DC METRO) OR 888-728-3250